Interim Affordability Report
January 24th, 2007
Blue Cross & Blue Shield of Rhode Island

Submitted in Conjunction with April 2007 Direct Pay Rate Filing

In accordance with the Order and Decision of the Health Insurance Commissioner in the Blue Cross & Blue Shield of Rhode Island ("BCBSRI") filing for Non-Group Subscription Rates for Plan 65 (OHIC-2006-4) (the "Order and Decision"), BCBSRI is submitting this Interim Affordability Report to describe its company wide strategies to enhance the affordability of its products. This Interim Report outlines in detail some of our current initiatives. For a complete explanation of each current and future initiative, please refer to the *Current Affordability Initiatives* plan dated January 9, 2006 and the *Future Affordability Plan* dated April 2006. This report is identified as an interim report pending further discussion with the Office of the Health Insurance Commissioner regarding the format of the report required by the Order and Decision. This Interim Report is formatted to be consistent with the bases for assessing "Affordability" as set forth in the Order and Decision.

I. Historical Rates of Trend for Existing Products

The following table illustrates the latest filed annual trend factors that were filed and approved for Class DIR for the respective year/benefit category:

Category	*Effective July 2002*	*Effective July 2003*	*Effective April 2006*
Inpatient	1.0885	1.1127	1.0885
Outpatient	1.0846	1.1065	1.1615
Surgical/Medical	1.1165	1.1259	1.0841
Major Medical	1.1152	1.0856	1.0841
Prescription Drugs	1.2078	1.0639	1.1000
Weighted Total	**1.1186**	**1.1015**	**1.1042**

The following table illustrates BCBSRI's filed trends versus those illustrated in a recent industry survey:

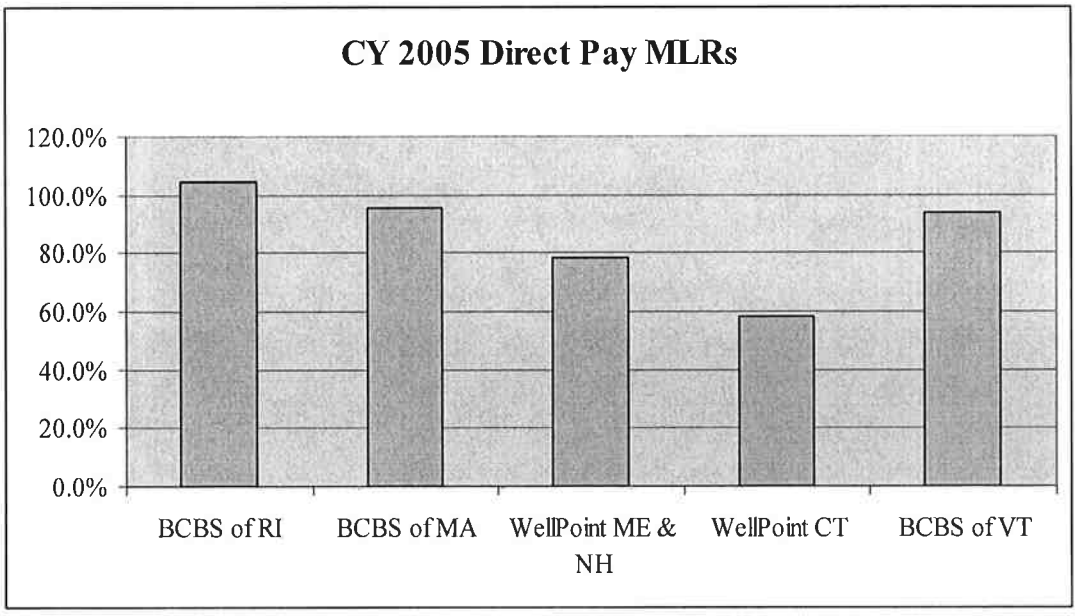
Source	*2002*	*2003*	*2006*
BCBSRI Class DIR Trends (from above)	12%	10%	10%
Mercer Survey Median mercer Trend [1]	17%	15%	10%

(1) Mercer Survey trend represents that Median Trend from industry survey. From *July 2006 Mercer Oliver Wyman Carrier Trend Report 2006.2 Analysis.*

II. Price Comparisons to Other Market Rates for Similar Products

A. Comparison of Medical Loss Ratios

The following chart was generated based on information contained in the NAIC blanks reported by each of the plans. They contain both Individual and Group lines as that is the basis for reporting in these documents. It shows a comparison of medical loss ratios for Direct Pay (non-group) coverage for the New England Blue Cross Plans. It shows Rhode Island as having the highest medical loss ratio. This would imply that relative to premium paid, BCBSRI Direct Pay members received the greatest benefit value.



B. Comparison of Rates for Similar Products

Attachment I is a comparison of the rates proposed in this rate filing to rates for similar plan types being offered by other New England plans in the non-group market. In general, rates in Rhode Island compare very favorably to the rest of New England. For all plan types, Pool 2 rates are lower than other New England states except for Connecticut, which is not guaranteed issue, and New Hampshire, which has a state sponsored high risk pool. Pool 1 rates are most comparable to the rates in Vermont and Maine. Both states are guaranteed issue and Vermont is entirely community rated while the rates in Maine vary only by age. The proposed Pool 1 rates are lower than the rates in Vermont and lower than most of the rates offered in Maine.

Attachment II is a comparison of recent rate increases for other New England plans to the rate increases requested in this rate filing. The results show that the 7.8% that we are proposing is in line with the rate changes being seen in other New England states. Specifically, Attachment II shows that rate adjustments across the plans range from
-5.5% to 15.7% excluding New Hampshire, with the majority of the increases in the 6%-15%

range. (New Hampshire has a state sponsored high risk pool so it would be difficult to use as a comparison since they do not pertain to any high risk subscribers that may exist in the pools of other states).

III. Means Testing

A. Direct Pay Premium Assistance Program

In 2006 BCBSRI instituted the innovative Direct Pay Premium Assistance Program to help lower income Pool I subscribers and absorb some of the escalating costs of health insurance premiums. This program is a direct outreach activity, authorized by the BCBSRI's Directors to help improve the affordability of healthcare coverage in Rhode Island for eligible subscribers who have acted responsibly by purchasing their own Direct Pay coverage, but (1) are not eligible for either employer or government sponsored or assisted healthcare coverage plans (i.e., employer group coverage (other than a self-employed individual), Medicare, Medicaid, or VA), and (2) have relatively low incomes from which to purchase coverage.

This program represents a central part of BCBSRI's overall corporate commitment to performing as a successful business enterprise, and then making a "return" from that success to the community. It is one of the ways in which we intend to fulfill our corporate mission to "provide our members with peace of mind and improved health by representing them in their pursuit of affordable high quality healthcare" (from our corporate mission statement). The Premium Assistance Program focuses directly on the issue of the affordability of the company's healthcare coverage for a segment of Rhode Islanders who are taking responsibility for covering their healthcare needs—but who have lower incomes and do not have the benefit of employer or government sponsored or supported plans available to them, yet they face a significant financial burden as they receive no assistance from employers or government in obtaining their health coverage.

Effective April 1, 2007 BCBSRI plans to expand this program to include lower income Pool II subscribers. We also plan to expand the program in additional ways described below. A separate report to the OHIC discusses our experience to date with the Premium Assistance Program.

Proposed changes to the Direct Pay Premium Assistance Program which will be effective April 1, 2007 include:

- Opening the program to members who have the Preferred Rate (Pool II);
- Increasing the highest income guideline from 300% to 350% of the Federal Poverty Level (FPL); this means that based on the 2006 FPL, individuals with an annual income lower than $34,300 are eligible for the program, as are families with an annual household income lower than $58,100 for a family size of 3;
- Use of the 2007 FPLs as the income guideline; and
- A 20% increase to the dollar amount of assistance provided to members who qualify for the program.

We estimate that after the program enhancements are implemented, that the percentage of people receiving assistance will increase from 8% of the direct payment population to 18%.

Eligibility for the Premium Assistance Program is open to Rhode Island residents who are enrolled or enrolling in one of our Class DIR plans and meets the following requirements:

- Annual gross household income level below 350 percent of the FPL with the highest level of assistance (Level 1) to those with 200% FPL or below, and a lesser level of assistance (Level 2) for those between 200% and 350% of FPL);
- Eligible recipients may not be eligible for coverage under Medicare, TriCare, or other federal programs nor eligible for coverage under RIte Care or other state programs; and they must not be eligible for employer-sponsored group coverage. Over the course of the 12-month rating period beginning April 1, 2007, the assistance is expected to provide an estimated $852 for each eligible Direct Pay individual subscriber and $1,608 for each corresponding eligible family subscriber with an income at or below 200% of the FPL. This equates to assistance ranging from 7% to 74% of total premium depending on the product selected.
- Additionally, Direct Pay subscribers who have incomes between 200% and 350% of the FPL, premium assistance over the course of the 12-month rating period is an estimated $564 for each eligible individual subscriber and $1,068 for each eligible family subscriber falling into this between 200% to 350% of FPL category. This equates to assistance ranging from 5% to 49% of total premium depending on the product selected.

The 2007 Federal Poverty Levels are scheduled to be released in February of 2007. Once released, BCBSRI intends to implement the new levels on the income guidelines for April 1, 2007. 2006 Federal Poverty Levels are as follows:

Family Size	*100%*	*200%*	*300%*	*350%*
1	$9,800	$19,600	$29,400	$34,300
2	$13,200	$26,400	$39,600	$46,200
3	$16,600	$33,200	$49,800	$58,100
4	$20,000	$40,000	$60,000	$70,000

It should be noted approximately 7,500 or 78% of Direct Pay contracts are for individual coverage. With respect to family coverage, the average size family in Direct Pay is three persons.

Last year, BCBSRI set aside a total of $4.5 million as seed money for this program. We expect to use $0.5 million in this rate year (2006) and because of program expansion, approximately $1.5 million in rate year 2007. The remaining monies could be drawn down in order to continue payouts under the program during periods when BCBSRI's financial results may not enable a dividend or "return" in the form of additional funding. BCBSRI's goal, however, is to generate sufficiently favorable ongoing financial results so that a portion of the favorable results can continue to be available to fund worthy programs such as the Direct Pay Premium

Assistance Program. Specifically, for 2006 BCBSRI will set aside an additional $4.5 million for the Premium Assistance Program, bringing the total 2 year contribution to $9.0 million.

B. Optima

BCBSRI has implemented a Special Needs Plan in the Medicare Advantage market that is specifically designed for low income members that are dually eligible for Medicaid and Medicare. This is essentially a zero dollar premium product that most certainly addresses "Affordability" in the senior market.

IV. Pricing Strategies

A. Product Portfolio

i. High Deductible plans and HSAs

In all of our markets we have implemented high deductible plans and HSA's as options that are more affordable for our members. This is an on-going process where the level of the deductibles and copays are constantly reviewed.

ii. Plan 65

Several changes in policies or initiatives were recently instituted and approved by the OHIC for Plan 65. These include:

a. Age-in Credit Program

The Age-in Credit Program is designed to increase enrollment in Plan 65 and Plan 65 Select plans and attract younger, healthier enrollees. Members who enroll in a Plan 65 or Plan 65 Select plan within six months of becoming eligible for Medicare Part B as primary payer will receive a 30% discount on their rate for the first year they are enrolled, a 20% discount their second year, and a 10% discount their third year. After the third year, the enrollee pays the non-discounted rate.

The introduction of this Age-in Credit Program is expected to encourage more age-ins to select Plan 65 plans in the upcoming years. This influx of more relatively young members is expected to have a favorable impact to the overall Plan 65 pool as our analysis shows that these members incur approximately 35% fewer claims than the average BCBSRI Plan 65 member. We believe that the introduction of these discounted rates will help attract more age-in subscribers and improve the overall Plan 65 pool, thus moderating future rate increases.

b. *Select Plan L*

The second program aimed at affordability is our Plan 65 Select Plan L offering. Plan L is differentiated from other Medigap plans offered by BCBSRI by its lower required premium, higher cost sharing and an annual out-of-pocket limit. The benefits of the Select Plan L offering should encourage more appropriate utilization of medical services and resources while attracting healthier enrollees as well.

As part of the Select Plan L benefit design, the Part A portion pays 75% of the Part A deductible for days 1-60 of a hospital stay, 100% of the Part A co-payments for days 61-150 of a hospital stay (while Lifetime Reserve Days are being used), and up to 365 fully paid additional hospital days after all other Medicare hospital benefits have been depleted. However, since this product is being offered with our Select network, members will not be required to pay their portion of the Part A deductible when they utilize network hospitals. Also, emergency hospital services are covered in full, regardless of provider. The co-payment for skilled nursing facility benefit is covered at 75%. The Part B portion of Select Plan L pays 75% of the Medicare Part B coinsurance after the Part B deductible has been met. It also pays 100% of the coinsurance for Part B preventative services and pays 75% of the first three pints of blood (or its packed red blood cell equivalent) unless it is replaced. Finally, Select Plan L pays 75% of the cost sharing for hospice care. Select Plan L has an annual out-of-pocket (OOP) limit of $2,070 in 2007.

c. *Changes in Product Eligibility Guidelines*

- Annual enrollment into our Medigap plans occurs from November 1st thru November 30th annually. As part of our initiative to increase affordability, BCBSRI has looked into making enrollment into lower premium Medigap plans easier and more readily available for Medigap prospects. Presently, current Medigap members who wish to switch from one Medigap plan to another must pass medical underwriting and can only switch plans during open enrollment. BCBSRI is proposing that Plan A, Select C and Select L be available to these Medigap members at any time, including those who do not pass medical underwriting at the standard premium rate. This would allow members to take advantage of network savings without impacting their benefits or to be able to move to a less rich plan. Since the premium differences between these products are in line with their benefit or network values, we believe that this makes sense to allow and does not impact the rates.

- For new members wishing to enroll into a Medigap plan, BCBSRI is proposing that Plan A and Select L be available for enrollment to all members, including those who do not pass medical underwriting. New Medigap members would be eligible for the Age-in credit Program if they meet the aforementioned criteria. Finally, BCBSRI is proposing a

continuous open enrollment for both Plan A and Select Plan L, making an annual open enrollment period unnecessary.
These changes allowed more members to take advantage of the Select product which offers savings through our hospital discounts as well as creating permanent open enrollment availability. All of these initiatives have helped to make Plan 65 products more affordable.

iii. Medicare Advantage

Effective January 1, 2006, pursuant to a contract with the Centers for Medicaid and Medicare Services (CMS), BCBSRI began to offer a "special needs plan" in the senior market. This Medicare Advantage plan effectively bridges Medicare and Medicaid into one managed care program. Optima is available exclusively to members that are "Dual Eligible" for Medicare and Medicaid and is intended for lower income members. This program is available at a zero dollar premium. In addition to standard Medicare benefits, the program offers additional benefits for these members to make the most efficient use of our healthcare system. In addition to Optima, BCBSRI offers several other Medicare Advantage benefit plans with varying cost sharing levels and premiums.

iv. Pharmacy

a. Expand the Profiling Process for Pharmacy Programs

As part of an ongoing program, BCBSRI Medical Directors provide educational feedback to physicians based upon periodic analysis of key practice indicators. The reason for expanding the program to include relevant prescribing information is to ensure that doctors are utilizing appropriate and cost effective medication therapies.

Pharmacists will be accompanying BCBSRI medical directors on educational visits to specific physicians. Previously, none of the visits have had a pharmacy component. The expansion effort targets BCBSRI medical directors to also be visited by a pharmacist. The pharmacist discusses the results of the physicians' pharmacy profiling reports. BCBSRI pharmacists maintain baseline data on the physicians that the pharmacists will be visiting. The BCBSRI medical director team and the pharmacist team work together to determine which specific physicians would benefit from an educational visit from a pharmacist. The pharmacists analyze prescribing date. The objective is that the physicians visited by a pharmacist will demonstrate improvement, if needed, in their prescribing patterns, i.e., prescribing the most appropriate, cost effective medication therapy. The pharmacists will continue to review prescribing data subsequent to the visit to the physician to determine whether their prescribing patterns have demonstrated improvement. Follow-up feedback to the doctors will be provided as needed. When physicians follow best practices with respect to prescribing, favorable outcomes should be achieved in an optimal timeframe.

b. *Promote the Member Generic Voucher Program*

Previously, BCBSRI had a generic voucher program which targeted members who were filling prescriptions for brand name drugs that had a generic equivalent available. The member received a letter advising him/her that there was a less expensive generic equivalent available. The member also received a coupon or voucher which allowed him/her to obtain a one month's supply of the generic at no cost. The process included tracking to determine if those members who took advantage of the voucher continued to utilize the generic medication. This program was very effective and has been re-instituted with BCBSRI's new pharmacy benefit manager. In October 2006 the Generic Copay Waiver Program was reinstituted. The initial mailing was sent to all members using the following medications: proton pump inhibitors and Tricor. The next mailing will target members using drugs to treat hypertension and diabetes. The mailing targeting members utilizing cholesterol medications is on hold until the anticipated drop in the price of generic simvastatin and pravastatin occurs.

c. *Expand the MedVantx Pilot Program*

BCBSRI has partnered with a company called MedVantx to install ATM-like machines known as Sample Centers in physicians' offices across the State. The Sample Center facilitates dispensing of a free 30-day sample of generic medications. Participating physicians receive the Sample Center in their offices at no cost. BCBSRI pays an administrative fee to MedVantx and also pays for the cost of the claim. As of November 2006, the Medvantx sample center has been installed in 34 physician offices and is available to 216 physicians. BCBSRI continues to expand the generic sampling program with additional physician offices targeted in 2007. While BCBSRI continues to roll out the MedVantx Program to interested participating physicians, there will also be an evaluation of key measures associated with the value of this program to ensure that the primary objectives are being met.

The MedVantx Program increases the dispensing of generic drugs and decreases the utilization of brand name medication leading to a reduction in the overall drug expenditures and a reduction in member's out-of-pocket expenses.

d. *Promote the Use of First Generation Antibiotics*

This initiative is designed to implement a clinically based education program focused on providers to increase awareness of appropriate use of first generation antibiotics. BCBSRI will establish a retrospective review program which evaluates the prescribing of antibiotics and whether or not specific physicians could improve their prescribing practices in this regard. This initiative will be incorporated into the comprehensive pharmacy profiling process which will seek to educate physicians by comparing their prescribing patterns to that of their peers and to other relevant benchmarks. Continued inappropriate prescribing may lead to financial disincentives for the physician.

This clinically based education program will "remind" doctors to prescribe antibiotics appropriately, using first generation medications before moving directly to more costly antibiotics. The Physician Antibiotics Education Report will target about 700 BCBSRI prescribers with information that documents first line versus second line antibiotic use benchmarked against their specialties. These reports are slated to be distributed in January 2007.

e. *Potentially Recommend a Change to the Rhode Island Generic Prescribing Law to Reflect Massachusetts Generic Prescribing Law*

This potential legislative effort would request that the Rhode Island General Laws regarding pharmacy be amended to restrict the dispensing of brand name drugs with available generic equivalents only upon written authorization of the physician. The patient directed choice of a brand drug would be prohibited.

BCBSRI is currently evaluating whether to pursue a bill of this type as part of its legislative agenda for 2007. BCBSRI efforts to enhance the utilization of generic medications have been very successful over the last few years.

f. *Over the Counter (OTC) Options Program*

The OTC Options Program is designed to communicate to our members that OTC medications offer a safe, effective, and lower-cost alternative to many brand-name drugs. Members eligible for the program will be identified based on past pharmacy claims for brand name prescription allergy medications. OTC loratadine (Claritin) is generally lower cost than other drugs used to treat allergies such as Allegra, Zyrtec, Clarinex, or Singulair. The OTC Options Program will be rolled out in April 2007. The Program will target any BCBSRI member who is taking prescription non-sedating antihistamines (Allegra, Clarinex, Zyrtec) urging them to switch to loratadine. Additionally, we will target members on Singulair monotherapy and ask them to switch to loratadine, if appropriate. BCBSRI will provide coverage for the over the counter medications for a designated length of time.

B. Provider Payment Strategies

i. *Primary Care Stakeholders Group*

BCBSRI has taken a very active role on the steering committee of the Primary Care Stakeholders group, a group created by the OHIC which is designed to create new programs that change the healthcare delivery system to better support primary care. The two key activities of that group thus far are listed below:

a. *Improving After-Hours Access to Primary Care*

This year long pilot program is designed to create incentives for infrastructure development in the primary care office that supports patient centered primary care. This pilot will provide incentive payments to selected primary care offices that expand after-hours access to appointments for both routine preventive care and acute illness care. In total, pilot practices will be primary care providers to a minimum of 20,000 patients.

BCBSRI will work with other insurers (United Health Care, NHP, Medicaid) and purchasers to provide an incentive payment to selected primary care physician (PCP) groups to provide scheduled evening hours.
There will be three outcome measures of this pilot:

Measure 1: Patient Satisfaction with Appointment Availability

Measure 2: After-Hours Office Utilization

Measure 3: Emergency Department (ED) Utilization

Pilot practices will receive 50% of the total incentive payment for participating. They will receive this in four equally divided quarterly payouts.

In addition, practices are eligible to receive an additional 50% of the incentive payment for meeting utilization benchmarks. A stakeholder sub-group (the Pilot Fund Board) would adjudicate whether or not benchmarks have been met.

Total dollars available to practices (participation incentive plus utilization incentive) will be $50,000 per practice per year. Ten practices will be in the initial pilot, for a total pilot cost of $500,000 and each involved insurer will be contributing their pro rata share (based on membership) of that total. The proposal is still under consideration by the PCPs and the Primary Care Stakeholders committee awaiting a formal response. If approved, the program should begin in the second quarter of 2007.

In addition to the above program, in 2006 BCBSRI responded to the concerns of the primary care community regarding payment for after-hours care by increasing our reimbursement for the after-hours code 99050. Other payers have NOT been willing to follow suit. It is our belief that strong support of after-hours access will lead to reductions in inappropriate and expensive emergency department utilization.

ii. Improving Chronic Illness Care

BCBSRI is a leading participant on the OHIC sponsored committee, Chronic Care Sustainability Initiative (CSI) for RI. As a result, we have agreed to defer our individual pilot program in favor of a statewide collaborative process that is consistent amongst all health plans. The project is designed to create reimbursement

methodologies that support PCPs to implement sustainable policies and processes to improve the care for the chronically ill.

The goal of this project is to align chronic care improvement goals and financial incentives for the delivery of high quality chronic illness care. This will be accomplished through primary care practice redesign to incorporate the elements of the "Advanced Medical Home/Chronic Care Model" of care. These elements include a host of activities that are rarely seen in the typical practice today, such as: better use of non-physician team members, integration of behavioral health into the primary care practice, enhancements to information systems, links to effective community resources, modern self-management support, group visits, "brown bag" medication review, electronic "virtual" visits, improved care coordination across the various settings of care, etc.

Our intent is to align our pilot project with that of the statewide Primary Care stakeholders group. We expect to have 35 – 50 PCPs involved in the program over a two-year period. Although the details are yet to be finalized, we anticipate payment on a capitated basis, based on number of members with one or more of the specified diseases. Measures of success of the program will include improved patient satisfaction, improved provider satisfaction, reduced inpatient/emergency room utilization, and improved outcomes.

a. Pay For Performance (P4P) Contracting

BCBSRI has been involved in P4P contracting with a number of PCP groups over the last few years. These programs involve creating contracts that incent doctors to provide high quality, cost effective care, which is measurable. This activity has expanded over the last year, with more dollars at stake and more physicians involved in our programs. Examples of P4P measures include, but are not limited to:

- Discussions with members regarding end of life care/advance directives;
- Use of generic drug prescribing;
- Frequency of electronic prescribing;
- Childhood immunization scores; and
- Use of electronic disease registries to track patients with various chronic diseases.

iii. Hospital Reimbursement Strategy

The hospital contracts that are due for renewal in 2008 and 2009 will be closely evaluated, and an aggregate lower rate of increase will be negotiated. BCBSRI will continue to negotiate the best discounts reasonably possible from hospital charges.

Through the Blue Cross Blue Shield Association, BCBSRI is able to realize savings through negotiated discounts from hospital charges nationwide. The current savings

associated with the current discounts for this out-of-state hospital program amount to $200,000,000 on an annual basis corporate-wide.

iv. Blues Center of Distinction (COD)

The goal of this program is to promote the establishment of centers of distinction (COD) within Rhode Island to reduce the migration of members to institutions located outside of the State. This program is based on our participation in the Blue Cross Association "Blue Distinction" program, which uses evidence based standards of care to establish a list of centers of excellence for specified procedures.

As a result of this program, we expect to see a reduction in post-surgical complications at hospitals designated as CODs. Structure, process and outcomes are measured and weighed to earn the designated distinction. While we have found no hard data to date which identifies specific savings, it is our understanding that these savings do exist. If qualification for the distinction is based on quality, it is expected that better outcomes with fewer post-surgical complications will save money.

v. Physician Reimbursement Strategy

BCBSRI anticipates making modifications to its physician fee schedule in the second quarter of 2007. In April of 2006, BCBSRI increased its physician fee floors to 105% of the 2005 Rhode Island Medicare Fee Schedule for most services and a floor of 109% of the same schedule for selected office based evaluation and management codes and mammography codes. In an effort to maintain market competitive physician fees and address affordability, BCBSRI does not anticipate an aggregate physician fee increase in 2007.

vi. Radiology

Currently, in the United States more than $200 billion is spent annually on high-tech health treatment and services. The spending accounts for nearly one-sixth of our nation's total health care costs. It has been recognized nationally and locally, that radiology is a top health care cost driver. Increasingly, plans across the country are taking steps to manage these costs. In response to this data, BCSRI has looked at the data and will implement several radiology initiatives to moderate this trend to acceptable levels.

A summary of key facts impacting this decision follows:

- The cost of Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CT) is rising three times faster than any other physician services.

- The utilization increases of High End Radiology from 2004 – 2005 for the BCBSRI Commercial and Medicare products are as follows:
  - Commercial CT = 7.2%, MRI = 5.8%

- Medicare CT = 5.5%, MRI = 15.2%
- In Rhode Island, CT and MRI represent roughly 90% of all the high-end radiological services performed.

- The area of greatest expansion is the number of non-radiologist providers filing for high end radiology services. This volume increased by 22% in 2005. The network of Radiologists as a specialty had a 1% decrease in 2005.

Over the course of the next year, BCBSRI will implement a privileging program to ensure better quality of radiological services, implement a recommended pre-authorization program to ensure appropriate utilization (services will be reviewed for medical necessity), enact new policies to curb the waste of dollars in the system and appropriately align reimbursements for radiological services. More information on each initiative is provided below:

a. *Provider Privileging Program*

The goal of this program is to eensure that providers rendering and billing for radiological services have adequate equipment and qualified staff that meets well established national standards for their equipment as well as their technical and professional expertise. Parameters will be established that outline necessary steps for reimbursement for testing and reading various radiological tests.

Through the elimination of sub-standard radiological machines from the BCBSRI network; the establishment of credentialing criteria for the testing and reading of radiological procedures; the quality of the images produced and their interpretation should meet or exceed national.

b. *Prior Authorization Program*

The prior authorization program for radiology will be implemented by January 1, 2008. Under this program, prior authorization will be required for radiology services. The purpose of the radiology prior authorization program is to monitor and control the appropriate utilization of high-cost tests performed by all participating radiology providers. Year one total savings based on Vendor RFP responses are estimated to be roughly $4-$6 million.

c. *Reduce Standard Radiology Fee Schedule*

A reduction in standard fees for high-end radiology tests will result in a corporate wide annual savings of $1.5 million. The prior authorization program, which will be implemented January 1, 2008, is intended in part to prevent inappropriate utilization as a result of decreased reimbursements.

d. *Implement Medicare Multiple Radiology Procedure Policy*

BCBSRI has adopted policies similar to those implemented by the Centers for Medicare and Medicaid Services (CMS) related to multiple procedures for a single diagnosis, and which occur at one sitting. This policy results in a reduction of reimbursements for follow- up or repetitive testing. In August of 2006 the BCBSRI policy adjusted reimbursements to 25% less than standard reimbursement rates for procedures subsequent to an initial assessment. On January 8, 2007 the percentage will increase to 50%.

vii. Physician Profiling

Physician profiling is the process in which individual physicians or groups of physicians are compared to others in their same specialty with regards to total annual claims cost and overall outpatient service utilization. The data reviewed falls into several large categories, including office visit services, diagnostic imaging, laboratory testing, and surgical/procedural services. From each of these categories, the data can be drilled down further to specific services by CPT code. The following is an outline of the process:

- The provider is selected for review through a variety of mechanisms that include:
    - Normal provider profiling process, i.e. higher number of services per patient and/or cost per patient when compared to other physicians in the same specialty.
    - A referral to BCBSRI's Special Investigations Unit by a member, provider, national fraud association, law enforcement or other interested party.
    - Analysis performed by another operational area within BCBSRI that shows potential issues with the provider's delivery of services or billing patterns.
- The provider's data is reviewed by the Medical Director to determine if further review is warranted or if there are legitimate reasons for the aberrancy (subspecialty, unique patient population, etc). The case can be closed if the variance is explained/expected.
- If there is no obvious reason for the higher statistics, a random sample of 15 office records is requested from the provider in the area(s) where the provider most differs from his/her peers.
- Office records reviewed may be screened by a Registered Nurse and findings are summarized for the Medical Director's review. In some cases only a Medical Director may perform the review of the sample records.
- The Medical Director either closes the case based on the documentation in the office records or discusses the issue(s) with the provider, usually in a face to face meeting.

- The Medical Director discusses the issue(s) with the provider and, based upon their conversation, either closes the case or indicates to the provider our concerns with his/her practice patterns and expresses BCBSRI's expectation for improvement. The Medical Director sends the provider a letter following the meeting documenting the following:

- The improvements BCBSRI would like to see in the provider's practice pattern. The letter also explains that BCBSRI will review the provider's practice pattern in a time period specific to the services in question and in general. For example, situations where a provider is performing high volume unnecessary services in his/her office, it is expected that the provider can improve immediately and that such improvement will be apparent in as little as one to three months of claims. More complex issues may require a longer time period for improvement and claims run out for accuracy of data.

- The provider will be referred to the Medical Peer Review Committee (MPRC), which is composed of a number of local physicians from various specialties, if he/she fails to improve in one or more of the targeted areas within the designated timeframes.
  BCBSRI conducts a follow-up review of the provider's data within the time period specified in the letter to the provider. If improvements have been made a letter is sent to the provider noting the improvement. If the requested improvements have not been made, the case goes back to the MPRC for review and their opinion on the next steps.

When providers improve their efficiency and reduce the variability in their practice, unnecessary expenditures are avoided and the quality of care may improve. BCBSRI has found this program to have a defined return on investment over the last several years. For 2005, we realized $0.35 per member per month savings from this program.

We have recently completed the installation of new software that will allow us to incorporate some quality data into our physician reporting for select products. We are in the process of user acceptance testing and are planning implementation for the second quarter of 2007.

C. Active Management of Chronically Ill Population

i. Disease Management

a. Disease Management (DM) Programs are developed based on claims utilization and cost drivers for inpatient and outpatient services and the likelihood that interventions can reduce further costs. These are tailored toward managing the challenges of living with a chronic condition while achieving personal best health.

b. BCBSRI has developed Asthma, Congestive Heart Failure, Coronary Artery Disease, Diabetes, COPD (Emphysema), and Smoking Cessation in response to these analyses. Effective DM reduces complications and acute exacerbations of chronic disease while saving dollars by improving health.

c. Members are systematically identified through a predictive model and stratified into three levels: low, moderate, and high risk for future high costs and morbidity. Each level of stratification receives interventions appropriate for the stratification level.

- Low risk members with one of the chronic conditions receive educational and awareness materials to promote healthy lifestyle choices, nutrition, exercise, and medication compliance. Approximately 90% of our members fall into this category.

- Moderate risk members with one of the chronic conditions receive telephonic outreach calls to participate in a member centric educational and self-management program with a nurse or dietician. The program length is determined by the goals established and the member progress toward the goals. Approximately 3% of members fall into this category.

- High risk members with one of the chronic conditions receive telephonic outreach calls from nurses, dieticians, and/or social workers to participate in a case management program. The program length is determined by the goals established and the member progress toward the goals. Approximately 7% of members fall into this category.

ii. Asthma Program (21,000 interventions)

Our Asthma Program is designed to help members better manage their disease and improve their quality of life. Members are offered education tools and resources through direct mail, newsletter articles, and the BCBSRI website. Our Asthma Program offers:

- Age-specific asthma tool kits containing self management tools and educational resources.

- Free asthma class taught by certified asthma educator.

- Quarterly provider notification of patient prescription pattern.

- Case Management Services (for those who qualify).

iii. Coronary Artery Disease/High Cholesterol Program (15,800 interventions)

This program is designed to help members, in coordination with their healthcare providers, take control of their cholesterol and coronary artery disease.

Those in case management or telephonic health coaching have access to the following resources:

- Informational materials on the basics of heart disease, nutrition, physical activity and stress, and a weekly pill organizer to help with medication compliance
- Registered nurse care managers who teach participants about the basics of heart disease, medications, nutrition, exercise, and stress, in coordination with their healthcare provider
- Registered dietitians who can provide individual telephonic nutrition counseling
- For those who need extra help coordinating their care, our certified nurse and social work case managers work with the patient and healthcare provider.
- Those in the mail program receive a series of mailings that includes:
    - Educational materials about the basics of coronary artery disease, high blood pressure, high cholesterol, nutrition, stress, and exercise
    - Recipes
    - A medication tracker to increase medication compliance.

In addition, all participants are eligible for our smoking cessation programs.

iv. Diabetes Program (23,000 interventions)

BCBSRI's Diabetes Program is designed to enhance and reinforce good self management practices begun in the office or hospital setting.
Multiple resources provide key elements for maintaining a healthy lifestyle. These resources include:

- Information about diabetes self-care, smoking cessation, and healthy living. Community glucose meter training and trade-in programs are held throughout Rhode Island
- Reminders for important diabetes-related exams and tests
- Diabetes classes – offered throughout the state in the daytime and evening (covered benefit with co-pay), and are taught by teams of Rhode Island Certified Diabetes Outpatients Educators (CDOEs), which consist of dietitians, nurses and pharmacists

- Individual consultation and education with CDOEs (covered benefit, co-pays or coinsurance may apply) For those who need extra help coordinating their care, our certified nurse and social work case managers will work with the patient and physician/provider.

v. *Heart Failure Program (4,200 interventions)*

This program is designed to help members, in coordination with their healthcare providers, take control of their congestive heart failure and improve their quality of life. The program interventions include case management, telephonic health coaching, and a mail program. As stated above, depending on the severity of their illness, members are eligible for a specific intervention. All participants are eligible for our smoking cessation programs.

Members in case management or telephonic health coaching have access to the following resources:

- A self-care handbook and teaching video, a digital scale, and a weekly pill organizer to help with medication compliance
- Registered nurse care managers who teach participants about the basic of heart failure, medications, nutrition and how to monitor weight and symptoms, in coordination with their healthcare provider
- Registered dietitians who provide individual telephonic nutrition counseling
- For those who need extra help coordinating their care, our certified nurse and social work case managers work with the patient and healthcare provider.

Members in the mail program receive a series of mailings that includes:

- Educational materials about the basics of heart failure, high blood pressure, high cholesterol, stress, exercise, and the importance of daily weights and a low salt diet
- Healthy Recipes
- Behavior change monitoring tools such as a medication tracker, and daily weight log sheet.

vi. *Depression Program (3,100 interventions)*

The specific goal of the Depression Outpatient Management Program is to promote education of members to effectively and adequately manage their symptoms and maximize functional capacity. Achieving this goal depends on promoting patient-practitioner partnerships that will foster patients' ability to manage their disease. To this end, the BCBSRI Depression Management program provides:

- Case management screening and referrals, recognition of potential co-morbidities such as cardiac events or Diabetes and Post-Partum

- Depression information for new mothers

- Provider toolkits which provide screening and referral options for the office visit

- Depression medication compliance notices to providers as well as reminders to members of the importance of adhering to medication management

- Web-based interventions including a provider locator and depression self-screening tools

- Timely mailings to members targeted at instances when depression occurs most frequently

vii. Telephonic SmokeFree Program

In addition, BCBSRI offers a Telephonic SmokeFree Program that is designed to help members who smoke and who have a chronic condition (e.g. asthma, diabetes, heart disease, COPD) to quit smoking. Members can enter the program by a self referral, referral from a physician, or referral from the disease or case management program. BCBSRI promotes smoking cessation as an educational component within all of its chronic condition management materials.

- Members are screened by the BCBSRI Disease Management and Case Management staff and referred to the Telephonic SmokeFree Program if appropriate.

- A tobacco treatment specialist then administers an individual treatment program consisting of between seven to ten individual sessions of 20 to 30 minutes long. The member receives information about smoking cessation and an individualized plan to quit smoking.

- If pharmacotherapy is indicated, the tobacco treatment specialist may contact the member's primary care physician (if the member approves).

- The telephonic counselor follows up with the member at least 6 and 12 months post quit date for additional support and counseling if necessary.

viii. Community Outreach

BCBSRI also conducts community outreach activities to engage members in self management. Community outreach activities include such events as Asthma Classes and a Glucose Meter Exchange Program.

The 2005 estimated savings for our Disease Management programs was $3.27 per member per month.

ix. Utilization Review

Utilization review functions ensure claims are paid only for services which are:

- Actually rendered,
- Billed in compliance with applicable subscriber agreements, and
- Medically necessary.

Additionally, these functions ensure that services are rendered in the most cost effective settings available, in keeping with the definition of medical necessity included in the subscriber contract.

The majority of utilization review is prospective or concurrent. This is done onsite at selected facilities and telephonically for others and includes review of services such as inpatient hospitalizations, rehabilitation, skilled nursing facility care, and out of network requests. Registered nurses conduct the review process in order to ensure our members are being efficiently managed throughout the continuum of healthcare. InterQual is a nationally recognized criteria utilized by more than 2,500 hospitals including the Hospital Association of Rhode Island. It is used as a screening tool for the nurses to determine the appropriate level of care for the member and make appropriate referrals to BCBSRI's Medical Director. As a result of the review process, reimbursement to a facility may be reduced or denied. During the review process, in addition to monitoring the length of stay, our nurses proactively identify and coordinate the member's discharge needs. In fact, we have a dedicated team of nurses and other support staff that help our hospitals with discharge planning by arranging for post hospital services, including transfers to skilled nursing facilities, and arranging for the delivery of necessary equipment to the home.

Other utilization review activities may also include review of selected programs and the appropriateness of certain medical equipment used in the home. The nurse will review clinical data specific to the member's needs and compare the request to the BCBSRI medical policies as well as the Medicare Guidelines. If the information provided meets the BCBSRI guidelines, a notice of approval is sent to all parties involved via fax or letter. If the nurse can not approve the request, the case will be referred to a BCBSRI Medical Director which may result in an adverse determination.

All adverse decisions are followed up with written documentation including a specific rationale and reference for the denial in accordance with the State of Rhode Island Rules and Regulations for Utilization Review of HealthCare Services. During the 2005 calendar year, collectively these services realized claims savings of $1.07 per member per month.

x. *Medical Policy*

The BCBSRI medical policy department is responsible for reviewing requests for coverage of new technology, changes in benefits, new mandates, and requests for revision to a current policy. Medical policies help us to determine whether medical services and/or supplies are medically necessary, experimental, investigational, or cosmetic in nature. In addition, all medical policies undergo an annual update. This annual review ensures that any changes to medical criteria are addressed and our policies are up to date with current practice. Policies are developed and/or modified for several reasons. We may receive a request for a new policy or modification to an existing policy from providers. In addition, our Medical Directors meet monthly with our appeals staff to review appeal statistics and reasons for overturned determinations. As part of our ongoing effort to be responsive to member concerns, if we find a consistent pattern of overturned determinations on a particular policy, the policy is reviewed again to be sure it is within current guidelines. Our policy request forms are available via paper or our website. Once a request is reviewed, the same process is followed.

- It is assigned to a staff member who begins the research and drafting process.
- A letter is sent to the requestor advising that we have received the request and we will have a determination within 60 days. Our current departmental turnaround time is 38 days.
- The policy developer researches several sources to obtain the latest information regarding the policy; this includes but is not limited to:
    - Peer-reviewed medical literature, such as The New England Journal of Medicine and the Journal of the American Medical Association.
    - Evidence-based guidelines developed by public health and nationally recognized health organizations such as the National Institutes of Health and the American Heart Association/American College of Cardiology.
    - The Blue Cross and Blue Shield Association Technology Evaluation Center comprised of physicians that are considered national experts in their field.
    - Regulatory agencies, such as the United States Food and Drug Administration agency (FDA).
    - Selected community participating physicians and healthcare professionals who would be affected by the policy and/or serve as members of our Specialty Advisory Committees.
- Our actuarial staff conducts a cost analysis.

- The draft policy is then presented to our Medical Review Committee which consists of representatives from internal areas such as contracting, marketing, legal, customer service. This ensures that that all factors are considered during the drafting and implementation process.

- Once a policy is finalized, a letter is sent to the requestor advising them of the outcome and, if applicable the implementation process begins.

Participating providers are notified in writing of any new or updated policies with 60 days advanced notice. In addition as of July 2005 we began making updated and new medical and reimbursement policies available via the BCBSRI.COM website. We will continue to add policies to this site in the coming year. In support of transparency in July 2006, we made these policies available on the web before authentication (on BCBSRI.COM go to Plans & Services, Services, Medical Policies). This allows non-participating providers and non-members access to our medical policies as well as our members and participating providers.

In addition to medical policies, the department is also responsible for creating and maintaining reimbursement policies. While these policies have no medical criteria, they do document our claims processing rules for certain services so providers are aware of correct billing procedures. These are also available on the provider web page. Estimated savings from our medical policy process for calendar year 2005 is $1.59 per member per month.

D. Wellness

As a health and wellness partner, BCBSRI understands the importance of prevention-oriented activities for maintaining good health. BCBSRI offers a comprehensive suite of health management solutions to help our members live long and healthy lives. Since prevention is the first line of defense against chronic illness and rising healthcare costs, BCBSRI offers individual, provider, and community-based programs designed to help all members from newborns to seniors reduce their risk of illness.

(In the following summaries, the numbers referenced are reflective of January through September 2006)

i. Little Steps Prenatal (2,000 enrolled)

This mail-based program helps take some of the guesswork out of prenatal care. After contacting BCBSRI to enroll, participants have the opportunity to receive one free pregnancy care book, a 20% discount on baby safety tools, and educational material for prenatal and newborn care. The program also focuses on the importance of recognizing and dealing with postpartum depression.

ii. Little Steps Newborn (8,000 enrolled)

The Newborn program waives copayments, if applicable, for well-baby visits during the first 15 months of life. Parents also receive a 20% discount on baby safety tools, and an option to receive a free book on newborn care. All eligible members are automatically enrolled in this program after the child is added to the parents' insurance.

iii. Little Steps Toddler (6,500 members)

Designed for children 12 months of age, the Toddler program automatically sends parents a newsletter filled with educational materials including information on childhood immunizations and lead poisoning prevention. This program also includes a newsletter with developmental information, and an option card to receive a free book on toddler topics.

iv. Women's Health (119,000 interventions)

As women have unique health concerns, BCBSRI provides them with a comprehensive guide that delineates appropriate health screenings for their age and answers common health questions women of all ages may have about screenings and tests. This guide is sent to members who have been non-compliant for one or more health screenings. These members will also receive telephonic reminders to schedule appropriate screenings with their healthcare provider.

v. Personal Health Assessment (PHA)

This completely confidential questionnaire is available to all members on BCBSRI.COM. The PHA helps members learn more about their personal health, the lifestyle choices they make that impact their health, and their personal attitudes about health and work. Members are asked a series of questions about their health risks, medical conditions, life satisfaction, and work and lifestyle habits. Upon completion, each member immediately receives a customized Personal Health Profile that includes comprehensive, personalized information outlining his or her individual health risk and practical suggestions to help him or her lead a healthier life.

vi. Online Health Improvement Programs

Any member interested in building a healthier lifestyle can take advantage of the online health improvement programs on BCBSRI.COM. These self-directed programs offer tailored information about five key wellness topics: back care, nutrition, stress management, weight management, and smoking cessation. Participants choose which topic they would like to focus on, and then complete a personalized questionnaire assessing their current health status and individual needs. Following the assessment, participants receive a tailored wellness plan along with customized web-based newsletters to help them stay on track.

vii. *Preventive Guidelines/Healthy Reminders (132,000 adolescents / 78,000 adult reminders)*

We offer our members preventive care guidelines for adults and children. These easy-to-read charts list recommended immunizations, screenings, exams, and health counseling at suggested ages across the life span. Recommendations are based on national standards of care and BCBSRI's own practice guidelines for providers. Our preventive programs address the following areas:

- Childhood immunizations
- Pap tests
- Teen immunizations
- Mammography
- Adult immunizations
- Chlamydia
- Adult & Child Preventive Health Charts

viii. *Choices Magazine (issued to all subscribers)*

BCBSRI's award-winning magazine is designed to help members make the best healthcare decisions possible. Improving and maintaining member health has so much to do with the lifestyle choices members make: what they eat…whether they exercise…and whether or not they get regular checkups. To make healthcare choices that will keep members healthy and help to keep healthcare costs down, members need information. Choices provides that information.

ix. *Programs in the Community*

All too often, the amount of physical activity children receive during a school day is less than optimal for developing bodies and minds. As health and wellness advocates, we realize that helping children be more active will help them stay healthy and have more energy for learning. To assist Rhode Islander teachers and parents in improving physical activity levels and reducing sedentary lifestyles, BCBSRI offers the following free programs to all Rhode Island schools:

x. *Feelin' Good® Mileage Club*

This teacher-lead walking program helps to boost the activity level of students grades K-Five. Regular walking activity is tracked by teachers and recorded in the classroom. Participating students are rewarded with colorful tokens for every five miles of walking. The objectives of the program are to create awareness of the

importance and benefits of regular physical activity for children and to teach children a fun and easy way to incorporate physical activity into their lifestyles.

xi. Move, Groove & Improve

This six-week program helps to increase the activity level of children ages six to 13. Participants complete daily activity logs and a program survey to become eligible for prizes at the end of the six-week period. This program was developed by BCBSRI in partnership with Kids First RI and the Rhode Island Department of Health. Move, Groove & Improve is available online through BCBSRI.COM. The objectives of the program are to create awareness of the importance and benefits of regular physical activity for children and help participants build a habit of regular physical activity that can continue throughout their lives.

xii. Community Wellness (10,500 encounters)

BCBSRI is dedicated to improving the health of all Rhode Islanders. Community events such as Walk Rhode Island and the BCBSRI Health & Wellness Van offer screenings, flu shot clinics, physical fitness classes and events, health education, and lectures open to anyone in the Rhode Island community. The community and Wellness Van schedule is available on BCBSRI.COM under the "In the Community" section.

xiii. Walk Rhode Island (1,400 participants)

Since 2000, BCBSRI has sponsored Walk Rhode Island. With the goal of improving the health of Rhode Islanders, this family-focused walking event is open to anyone. Traditionally offering a 2-, 5-, and 10-mile route, it is the only non-competitive, non-fundraising walk of its kind in the State that's perfect for people of all ages and fitness levels.

E. Healthcare Fraud

BCBSRI recognizes that fraud is a growing problem in today's healthcare system. The National Healthcare Anti-Fraud Association estimates that between 3% and 5% of healthcare expenditures were lost to fraud in 2003. At BCBSRI the anti-fraud activities are the responsibility of the Special Investigations Unit (SIU) within the Legal Services division.

The goal of the SIU is to detect, correct and prevent fraud, waste and abuse for all lines of business. Corporate-wide over 125 potential fraud cases were opened and investigated in 2005. The cases were referred from many sources, internally from Customer Service, calls to the Fraud Hot Line, the provider profiling program and referrals from management. Externally we have received referrals from the Rhode Island Attorney General's Office, the U.S. Office of Inspector General, the Blue Cross and Blue Shield Association, the National Healthcare Anti-fraud Association, Blue Cross & Blue Shield of Massachusetts and the Massachusetts Attorney General's office. We are also installing new anti-fraud software to assist in the detection of

potentially fraudulent and abusive billing practices. The software, produced by McKesson Health Solutions, identifies aberrant billing patterns through the use of proprietary algorithms that access the claims system. Installation of the new system is expected to be completed by the end of 2006 and will be operational in the first quarter of 2007.

The SIU investigates cases involving members and providers, including hospitals, physicians, pharmacies, and durable medical equipment suppliers. The types of cases involving members that were reviewed included members enrolling relatives that were not immediate family, members altering receipts from non-participating providers in order to receive more money, members using stolen prescription pads to obtain drugs and then selling them, identity theft and using their individual membership to obtain prescriptions for family members and doctor shopping. We also looked at cases involving providers that bill for services they didn't render, upcoding services to obtain higher reimbursement, unbundling of services, billing members for non-covered services, patient swapping and unlicensed providers billing our members.

In some instances a referral to law enforcement is necessary. In the past year we have made referrals to U.S. Attorney's office, the Office of Inspector General, the R.I. Attorney General's office of Medicaid Fraud Control Unit and the U.S. Drug Enforcement Agency.

While the SIU makes financial recoveries whenever possible, the goal of the unit is to prevent payment for fraudulent services from being made in the first place. It is much better to prevent funds from being paid out than it is to attempt to recover it later. It is difficult to project savings from year to year as the types and magnitude of the cases differ annually. Any recoveries and any funds that are prevented from being reimbursed obviously contribute to the affordability effort. We have estimated that with the implementation of the new software, our savings corporate-wide due to anti-fraud efforts will minimally be $600,000 per year.

F. Health Information Technology

BCBSRI remains committed to supporting the adoption and implementation of fully functional ambulatory electronic health records (EHR) into physician practices in Rhode Island. Many national studies over the last several years support the concept that widespread use of EHRs lead to improvements in quality of care and patient safety while at the same time reducing the overall cost of care.

i. *Quality Counts* – This is our Pay For Performance program which is designed to incent PCPs to purchase, implement, and utilize EHRs in their practices. We currently have contracts with 44 physicians to purchase EHRs, and 24 of the 44 are fully implemented. We expect another 56 physicians to be involved in the program by the end of 2007.

ii. BCBSRI has contracted with two of the largest primary care groups in Rhode Island that include incentives to implement EHRs into their practices. By the end of 2006, 125 primary care providers will be utilizing fully functional EHRs as a result of these contracts. An additional 17 primary care physicians will have EHRs by April 2007.

Of note, no other RI insurer has contributed **any** funding to support EHRs in physician practices in RI.

iii. *EHRRI* – BCBSRI contributed $300,000 for infrastructure funding to this organization back in 2005, and $550,000 in 2006 to assist more physicians of all specialties in the purchase of an EHR.

iv. *RI Quality Institute (RIQI)* – This organization, along with the Rhode Island Department of Health, has taken the lead in the development of the statewide Health Information Exchange. We are very much involved with the activities of RIQI. Our Chief Executive Officer, Mr. James Purcell, is a major participant on their Board of Directors, and we support this group's activities financially with the largest annual contribution of any stakeholder.

v. *The Physician Practice Support Center* – BCBSRI is a sponsor of The Physician Practice Support Center (contributing $150,000 in 2006) and will work closely with the staff of Quality Partners of RI to promote the successful deployment of EHRs. The Center will collaborate with EHRRI and the RIQI to assist physicians with the adoption of EHRRIs and the use of EHRs to extract data, analyze patterns, and improve healthcare outcomes.

G. Administrative Process

A number of our affordability initiatives are geared toward implementing simplified and effective administrative processes. Please see the attached Affordability Report to identify which of the initiatives is geared toward achieving this goal.

H. Promotion of Public Conversation

i. *Communications Campaign*

BCBSRI is actively working on the development of an affordability communications campaign regarding healthcare costs. The objectives of the campaign are to educate members on the drivers of rising healthcare costs as well as define what "concrete" steps they can take to help mitigate those costs for themselves as well as for the larger healthcare delivery system. This campaign will seek to create awareness among members, providers and general public regarding specific areas of rising costs. We hope to then engage the member/consumer to take action steps (web programs, speak to their physician, etc.) that result in changes in behavior and perspective as it relates to interacting with the healthcare delivery system. We are targeting a first quarter 2007 launch that will include television, print ads, website within BCBSRI.COM, and brochures/info sheets for members.

ii. *Community Meeting*

Annually, BCBSRI holds a Community Meeting where discussion of healthcare costs and issues are held. On September 26, 2006, about 250 people attended our Annual Community Meeting, "Today's Healthcare Costs: Perspectives on Care, Coverage and Quality".

This meeting was moderated by our CEO James Purcell and featured the following panel of speakers:

- Karen Ignagni, President and CEO, America's Health Insurance Plans
- Christopher Koller, Rhode Island Health Insurance Commissioner
- Edward Quinlan, President, Hospital Association of Rhode Island
- Kathleen Fitzgerald, M.D., President and CEO, Rhode Island Medical Society
- Laura Adams, President and CEO, Rhode Island Quality Institute

iii. Choices Magazine

On a quarterly basis Choices magazine has included articles addressing the topic of affordability. Choices is mailed to all subscribers. Choices TV Show also featured the topic of on Affordability during the first quarter of 2006 (Channel 10).

iv. Consumer Information

BCBSRI is an active participant in the Professional Provider-Health Plan Work Group, a subcommittee of the Health Insurance Advisory Council. This workgroup was established to address the state transparency mandate plan to implement specific transparency initiatives. BCBSRI has emphasized its willingness to participate and contribute to these efforts. We have identified concerns and our own guiding principles. The principles are as follows:

a. Collaboration between insurers and providers is necessary for transparency initiatives to reach their full potential.

b. Quality information should be transparent to the extent that it can be measured reliably.

c. Price information should be transparent only to the extent that it does not inadvertently increase costs for consumers. Concern that specific service level price transparency may have the unintended consequence of increasing health care costs.

I. Contribution to Reserves

BCBSRI's overall corporate statutory reserve as of September 30, 2006 was $364 million, or 22% of statutory accounting principles (SAP) premium. This is equivalent to 2.6 months of insured premium or 91 days of claims payments.

BCBSRI's reserve target is a range of 25% to 35% of annual insured premium. This target is a result of a review of our reserve requirements conducted by Milliman USA ("Milliman"), our consulting actuaries, in early to mid 2000 (updated in 2003). The purpose of the review was to determine the appropriate level of reserves in order to provide BCBSRI and its subscribers with the financial stability necessary to avoid a financial crisis such as that experienced by BCBSRI in 1996 through 1998 (The third such loss cycle experienced by BCBSRI since 1980). The 1996 through 1998 loss cycle not only endangered the future of BCBSRI as an independent, non profit, locally controlled Blues Plan, but also caused the demise of Harvard Pilgrim Health Care of New England and Tufts in Rhode Island. The Milliman study set our target range for corporate reserves at 25% to 35% of annual insured premium. A second opinion on our reserve requirement was sought from the actuarial consulting firm of Reden and Anders. The results of that study confirmed the validity of the Milliman's reserve range.

Recently, pursuant to a legislative directive, the OHIC conducted a study to evaluate the reserve requirements of Rhode Island's domestically located health insurers. The Lewin Group was retained by the OHIC to perform the study. They released a report earlier this year recommending a range 23% to 31% of insured premium for BCBSRI. In our analysis, the Lewin Report validated the necessity of adequate reserves and the reasonableness of our established reserve target.

Note that BCBSRI was ranked 29th out of 38 Blue Cross Plans nationally in health risk-based capital, as of June 30, 2006.

J. Other Community Outreach

BCBSRI is committed to working together with key stakeholders to provide healthcare services to the uninsured and address serious systemic issues impacting healthcare in Rhode Island. Our corporate social responsibility strategy includes these major initiatives:

i. Blue Cross Community Health Fund—in 2005 BCBSRI took a major step in demonstrating our commitment to the Rhode Island community by establishing the Blue Cross Community Health Fund, a donor advised fund with the Rhode Island Foundation. The Community Health Fund was established as a long term commitment to support non-profit agencies that provide health education and prevention services to the uninsured and underserved populations in our community. BCBSRI endowed the fund with a tax deductible contribution of $1.5M and we make recommendations regarding the distribution of money in the fund to local health related programs and services. We will continue to contribute to the fund as the financial stability of the company allows with a long-term goal of achieving a fund balance sufficient to provide health related charitable giving to neediest in our community on a self sustained basis.

ii. Over the past three years, the BlueAngel Community Health Grants and other charitable contributions have provided $2,237,000 to the community health centers, and approximately 200 other local agencies servicing the health care needs of Rhode Island's uninsured and under-insured.

iii. BCBSRI is the largest funding partner of the Rhode Island Quality Institute (RIQI) which is dedicated to improving health care quality by applying sound operational and technological approaches to the system of care statewide.

iv. In addition to supporting the RIQI, BCBSRI also supports statewide quality improvement efforts through its support of Quality Partners Rhode Island (QPRI). BCBSRI contributes both financially and/or with staff time to projects that are focused on improving quality in areas such as home health, hospital, nursing home and physician office settings.

v. Over the past few years BCBSRI also funded the Statewide Health Assessment Planning & Evaluation (SHAPE) study which focused on the demand for and supply of health services for Rhode Islanders. The nursing study in particular provided significant data to support recent efforts to address the nursing shortage in Rhode Island. Overall, SHAPE provided a transparent and inclusive process of objective research and analysis.

vi. BCBSRI has also been a major financial contributor to EHRRI. We know that electronic health records have the potential to improve the quality of health care delivery and improve efficiency through a reduction in medical error, elimination of duplication, and enhanced collaboration among healthcare providers.

vii. BCBSRI initiated the Rhode Island Health Literacy Project (RIHLP), a state-wide coalition of public health, adult education, and medical organizations. Through a collaborative approach, the RIHLP seeks to heighten awareness of health literacy issues so that all Rhode Islanders better communicate and understand health information, treatment options and self-care instructions. BCBCRI provides staff support and other resources to the RIHLP which is presently developing a RIHLP web site as well as programs/tools for: adults with low literacy, physicians/providers in communicating with patients, written material with consumer health messages.

viii. Through the Community Health & Wellness Van, the company also brings preventive screenings and wellness programs onsite to the community making over 270 visits to local senior centers and non-profit agencies throughout the state. BCBSRI also supports state boards and commissions with experienced professional staff that work collaboratively with community leaders to shape policies and interventions that improve public health.

V. Constraints

A. State and Federal Requirements

State mandated benefits, assessments, and regulations, along with Federal regulations must be adhered to and at times may pose limits on benefit designs, managed care levels, and/or the cost of services. Where these limits are imposed, BCBSRI should not be penalized in determining the assessment of Affordability efforts.

B. Program Costs

Some of these programs which are designed to enhance affordability in the long-term may actually initially result in increased administrative costs to establish and implement the programs. In addition, some initiatives may not have actual claims savings until a future date and in the interim may in fact increase claims costs to some extent. Moreover, while we believe our affordability initiatives are reasonable expenditures for which we expect some return, how much, if anything, will be saved in claims cannot always be quantified. We do not believe it is prudent to build unknown potential savings into rates. However, with certainty, as all affordability initiatives result in savings, those savings will roll directly into experience utilized to develop future rates and thereby directly and favorably impacting rates at the appropriate time. Furthermore, without adequate reserves and continued strong financial performance, the costs to continually design, develop, and implement these initiatives would be difficult to absorb.

VI. Trends by Service Category

The following table illustrates the overall trend factors by type of service filed for class DIR on November 20, 2006. The detailed regression analysis and graphs behind these factors were supplied with that rate filing.

Type of Service	*Projection Factor*	*Annual Trend Factor*
Inpatient	1.1773	1.0850
Outpatient	1.3092	1.1442
Surgical/Medical	1.1226	1.0595
Preferred Rx	1.2100	1.1000
Weighted Total	**1.1932**	**1.0923**

VII. Results and Explanation of Purpose of Initiatives

The attached "Affordability Report" gives a summary of all of BCBSRI's affordability initiatives, which spectrum of products they impact, and which affordability principles they support. Please see section V.B. of this report for a discussion of program costs and allocation of savings.

VIII. Applicability to this Rate Filing

Most of the initiatives identified in the Affordability Report are applicable to Direct Pay members.

The focus of many of these initiatives is to take cost out of the healthcare system. To the extent some initiatives reflect long standing BCBSRI practices (e.g. disease and case management programs, health and wellness activities, etc.), actual savings are reflected in claims costs and reflected globally in the Class DIR rates. Savings from these programs may not be individually identifiable. Similarly, the related savings for future initiatives may not always be quantifiable; however, to the extent savings are realized, over time they will be incorporated in the claims expense for Class DIR members.

Consistent with our financial goals, the Lewin Study, and other filings, this filing contains a reserve contribution factor of 2%. We feel that this addresses the requirement of the Affordability Guidelines to "allow for an appropriate contribution to reserves".

New England Blue Cross Blue Shield Plans by State

Direct Pay Product Offerings

	RHODE ISLAND	Deductible (Indiv/Family)	Rating Type (1)	Coinsurance IN/OON	Rating Pool	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	HealthMate CTC $400	$400/$800	MU/AG	10%/40%	Pool 2	$205	$292	$776	$1,129
			GI/C		Pool 1	$618	$618	$1,168	$1,168
B	HealthMate CTC $2,000	$2,000/$4,000	MU/AG	20%/40%	Pool 2	$154	$220	$585	$849
			GI/C		Pool 1	$464	$464	$879	$879
C	HealthMate CTC $3,000 HSA	$3,000/$6,000	MU/AG	0%/40%	Pool 2	$133	$189	$502	$728
			GI/C		Pool 1	$398	$398	$754	$754
D	HealthMate CTC $5,000 HSA	$5,000/$10,000	MU/AG	0%/40%	Pool 2	$105	$149	$398	$576
			GI/C		Pool 1	$314	$314	$597	$597

	MASSACHUSETTS	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	PPO Standard	$250/$500	GI/RA	$1 Mil	$614	$614	$1,450	$2,193
D	PPO Value (HSA compatible)	$5,000/$10,000	GI/RA	$1 Mil	$295	$295	$696	$1,052

Rates from MA Division of Insurance. All rates for Springfield area.

	VERMONT	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
C	PPO Option A	$3,500/$7,000	GI/C	None	$444	$444	$1,199	$888
D	Individual HSA Blue	$5,000/$10,000	GI/C	None	$331	$331	$893	$661

Rates and benefit info from carrier website. BCBSVT is the sole individual carrier in the state.

	NEW HAMPSHIRE	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
C	PPO Direct Blue HSA	$2,500/$5,000	GI/RA	$2 Mil	$117	$117	$496	$819
D	PPO Direct Blue HSA	$4,000/$8,000	GI/RA	$2 Mil	$102	$102	$418	$687

All rates are for non-tobacco users in the Concord area. New Hampshire has a state-sponsored high risk pool.

	CONNECTICUT	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	Century Preferred Direct 80/20 PPO	$250/$500	MU/AG	$5 Mil	$154	$219	$770	$1,216
B	Century Preferred Direct 100 PPO	$1,500/$3,000	MU/AG	$5 Mil	$130	$185	$650	$1,026
C	Century Preferred Direct HSA	$4,000/$8,000	MU/AG	$5 Mil	$100	$142	$500	$712

Rates and benefit info from carrier website.

	MAINE	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	PPO HealthChoice Standard	$250/$500	GI/A	$2 Mil	$722	$722	$1,914	$2,167
B	PPO HealthChoice Standard	$1,500/$3,000	GI/A	$2 Mil	$670	$670	$1,776	$2,010
B	PPO HealthChoice Basic	$1,500/$3,000	GI/A	$1 Mil	$572	$572	$1,517	$1,717
C	PPO HealthChoice (HSA Compatible)	$2,600/$5,200	GI/A	$3 Mil	$290	$290	$760	$823
D	PPO HealthChoice (HSA Compatible)	$5,000/$10,000	GI/A	$3 Mil	$194	$194	$494	$535

Rates and benefit info from carrier website.

(1) GI = Guaranteed Issue
C = Community Rated
A = Age Rated (no gender)

MU = Medically Underwritten
AG = Age & Gender Rated

RAG = Region, Age & Gender Rated
RA = Region & Age Rated (no gender)

New England Blue Cross Blue Shield Plans by Plan Type

Similar Direct Pay Product Offerings

	Plan Type A	Deductible (Indiv/Family)	Rating Type (1)	Rating Pool	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
RI	HealthMate CTC $400	$400/$800	MU/AG	Pool 2	$205	$292	$776	$1,129
			GI/C	Pool 1	$618	$618	$1,168	$1,168
MA	PPO Standard	$250/$500	GI/RA		$614	$614	$1,450	$2,193
CT	Century Preferred Direct 80/20 PPO	$250/$500	MU/AG		$154	$219	$770	$1,216
ME	PPO HealthChoice Standard	$250/$500	GI/A		$722	$722	$1,914	$2,167

	Plan Type B	Deductible (Indiv/Family)	Rating Type (1)	Rating Pool	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
RI	HealthMate CTC $2,000	$2,000/$4,000	MU/AG	Pool 2	$154	$220	$585	$849
			GI/C	Pool 1	$464	$464	$879	$879
CT	Century Preferred Direct 100 PPO	$1,500/$3,000	MU/AG		$130	$185	$650	$1,026
ME	PPO HealthChoice Standard	$1,500/$3,000	GI/A		$670	$670	$1,776	$2,010
ME	PPO HealthChoice Basic	$1,500/$3,000	GI/A		$572	$572	$1,517	$1,717

	Plan Type C	Deductible (Indiv/Family)	Rating Type (1)	Rating Pool	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
RI	HealthMate CTC $3,000 HSA	$3,000/$6,000	MU/AG	Pool 2	$133	$189	$502	$728
			GI/C	Pool 1	$398	$398	$754	$754
VT	PPO Option A	$3,500/$7,000	GI/C		$444	$444	$1,199	$888
NH	PPO Direct Blue HSA	$2,500/$5,000	GI/RA		$117	$117	$496	$819
CT	Century Preferred Direct HSA	$4,000/$8,000	MU/AG		$100	$142	$500	$712
ME	PPO HealthChoice (HSA Compatible)	$2,600/$5,200	GI/A		$290	$290	$760	$823

	Plan Type D	Deductible (Indiv/Family)	Rating Type (1)	Rating Pool	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
RI	HealthMate CTC $5,000 HSA	$5,000/$10,000	MU/AG	Pool 2	$105	$149	$398	$576
			GI/C	Pool 1	$314	$314	$597	$597
MA	PPO Value (HSA compatible)	$5,000/$10,000	GI/RA		$295	$295	$696	$1,052
VT	Individual HSA Blue	$5,000/$10,000	GI/C		$331	$331	$893	$661
NH	PPO Direct Blue HSA	$4,000/$8,000	GI/RA		$102	$102	$418	$687
ME	PPO HealthChoice (HSA Compatible)	$5,000/$10,000	GI/A		$194	$194	$494	$535

(1) GI = Guaranteed Issue
C = Community Rated
A = Age Rated (no gender)

MU = Medically Underwritten
AG = Age & Gender Rated

RAG = Region, Age & Gender Rated
RA = Region & Age Rated (no gender)

Actuarial and Statistical Analysis
1/24/2007

New England Blue Cross Blue Shield Plans by State

Direct Pay Product Offering - Rate Increases

	RHODE ISLAND	Deductible (Indiv/Family)	Rating Type (1)	Coinsurance IN/OON	Rating Pool	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	HealthMate CTC $400	$400/$800	MU/AG	10%/40%	Pool 2	5.4%	5.4%	5.4%	5.4%
			GI/C		Pool 1	8.9%	8.9%	8.9%	8.9%
B	HealthMate CTC $2,000	$2,000/$4,000	MU/AG	20%/40%	Pool 2	5.5%	5.5%	5.5%	5.5%
			GI/C		Pool 1	8.9%	8.9%	8.9%	8.9%
C	HealthMate CTC $3,000 HSA	$3,000/$6,000	MU/AG	0%/40%	Pool 2	5.4%	5.4%	5.4%	5.4%
			GI/C		Pool 1	8.9%	8.9%	8.8%	8.8%
D	HealthMate CTC $5,000 HSA	$5,000/$10,000	MU/AG	0%/40%	Pool 2	5.3%	5.4%	5.4%	5.4%
			GI/C		Pool 1	8.9%	8.9%	8.8%	8.8%

	MASSACHUSETTS	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	PPO Standard	$250/$500	GI/RA	$1 Mil	14.6%	14.6%	14.6%	14.5%
D	PPO Value (HSA compatible)	$5,000/$10,000	GI/RA	$1 Mil	15.7%	15.7%	15.4%	15.5%

Rates from MA Division of Insurance. All rates for Springfield area.

	VERMONT	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
C	PPO Option A	$3,500/$7,000	GI/C	None	5.7%	5.7%	5.8%	5.8%
D	Individual HSA Blue	$5,000/$10,000	GI/C	None	5.8%	5.8%	5.8%	5.8%

Rates and benefit info from carrier website. BCBSVT is the sole individual carrier in the state.

	NEW HAMPSHIRE	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
C	PPO Direct Blue HSA	$2,500/$5,000	GI/RA	$2 Mil	-15.2%	-15.2%	-23.7%	-20.0%
D	PPO Direct Blue HSA	$4,000/$8,000	GI/RA	$2 Mil	-1.9%	-1.9%	-14.5%	-10.7%

All rates are for non-tobacco users in the Concord area. New Hampshire has a state-sponsored high risk pool.

	CONNECTICUT	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	Century Preferred Direct 80/20 PPO	$250	MU/AG	$5 Mil	1.3%	5.3%	8.1%	9.4%
B	Century Preferred Direct 100 PPO	$1,500	MU/AG	$5 Mil	-0.8%	2.8%	5.5%	6.8%
C	Century Preferred Direct HSA	$4,000	MU/AG	$5 Mil	0.0%	7.6%	7.5%	11.9%

Rates and benefit info from carrier website.

	MAINE	Deductible (Indiv/Family)	Rating Type (1)	Lifetime Maximum	Single Male 25	Single Female 25	Family 35 Yr Old w/ Spouse & 2 Kids	Two Adults 63 Yr Old & 60 Yr Old
A	PPO HealthChoice Standard	$250/$500	GI/A	$2 Mil	10.7%	10.7%	10.7%	10.7%
B	PPO HealthChoice Standard	$1,500/$3,000	GI/A	$2 Mil	13.6%	13.6%	13.6%	13.5%
B	PPO HealthChoice Basic	$1,500/$3,000	GI/A	$1 Mil	13.3%	13.3%	13.5%	13.6%
C	PPO HealthChoice (HSA Compatible)	$2,600/$5,200	GI/A	$3 Mil	-5.5%	-5.5%	-5.5%	-5.5%
D	PPO HealthChoice (HSA Compatible)	$5,000/$10,000	GI/A	$3 Mil	1.0%	1.0%	1.2%	1.3%

Rates and benefit info from carrier website.

(1) GI = Guaranteed Issue
C = Community Rated
A = Age Rated (no gender)

MU = Medically Underwritten
AG = Age & Gender Rated

RAG = Region, Age & Gender Rated
RA = Region & Age Rated (no gender)

Attachment II

Affordability Report

Initiative	Spectrum of Products	Appropriate Incentives for Stakeholders	Focus on Primary Care, Prevention & Wellness	Manage the Chronically Ill	Least Cost, Most Appropriate Setting	Evidence-based Quality Care	Payment Strategies for Cost Effective Utilization	Simple & Effective Administrative Processes	Consumer Need for Cost Information	Applicable Products	Status
[C][F] Physician Pay for Performance Program "Quality Counts!"		√	√	√	√	√	√	√		All	In progress - 44 contracts executed. 24 of 44 fully implemented EHRs.
[F] Promote the Adoption of Electronic Health Records		√	√	√	√	√	√	√		All	In progress - Financial sponsorship and support provided to EHRRI and RIQI
[F] Sponsor the "Physician Practice Support Center"		√	√	√	√	√	√	√		All	In progress - Financial sponsorship and support provided to The Center to work in collaboration with EHRRI and RIQI.
[C][F] Advance Directive and End of Life Program		√		√	√	√	√	√		Medicare Advantage	Implemented - 1,600 services provided as of April 2006 when incentive payment was initiated.
[C] Enhanced Physician Profiling			√	√	√	√	√		√	All	Implemented - New software to incorporate quality data in physician reports in 2nd Quarter 2007.
[C] Intensive Care Unit (ICU) Collaborative					√	√		√		All	In progress - Most hospitals completed ventilator-associated pneumonia and catheter-related infections.
[C] Predictive Modeling				√				√		Excludes Plan 65 only	Implemented - Enhanced to include prescription drug information
[C][F] Disease Management Programs			√	√	√	√	√	√		Excludes Plan 65 only	Implemented
[F] Enhanced Case Management Programs		√	√	√	√	√	√	√		Excludes Plan 65 only	Implemented - Focus groups completed October 2006. New case management system in 3rd quarter 2007.
[C] Case Management Collaboration w/ Physicians		√	√	√	√	√	√	√		Excludes Plan 65 only	Implemented
[C] On-site Case Manager		√	√	√	√	√	√	√		Excludes Plan 65 only	New on-site program in 2nd Quarter 2007.
[C] Incentives for Case/Disease Management Referrals		√	√	√	√	√	√	√		Excludes Plan 65 only	Contracts concluded.

Initiative	Spectrum of Products	Appropriate Incentives for Stakeholders	Focus on Primary Care, Prevention & Wellness	Manage the Chronically Ill	Least Cost, Most Appropriate Setting	Evidence-based Quality Care	Payment Strategies for Cost Effective Utilization	Simple & Effective Administrative Processes	Consumer Need for Cost Information	Applicable Products	Status
[C] Inpatient Concurrent Review				√	√		√	√		All	Implemented - New role of patient advocate added with referrals to a health management program or follow-up with physician.
[C] Skilled Nursing Facility (SNF) Bed List					√			√		All	Implemented
[C] Discharge Liaison Team					√					Excludes Plan 65 only	Implemented
[C] Total Hip/Total Knee Joint Replacement Program					√	√				Excludes Plan 65 only	Implemented
[C] Billing Validation		√						√		All	Implemented
[C][F] Health and Wellness		√	√					√		All	Implemented
[C] Small Group Plan	√									Small Group Commercial	In progress
[C] Consumer-Driven Health Plans	√								√	Commercial (Small Group, Large Group, and Direct Pay)	In progress
[C] Medicare Advantage Risk-Adjusted Payments				√				√		Medicare Advantage	Implemented
[C] Reaching out to the Uninsured	√									All	In progress
[C] Improved Account Reporting		√	√		√	√		√	√	Commercial (Small Group, Large Group)	Implemented - Increased the number of profiles and provided web reports in 2006. Provide education and suggestions for improvement.
[C] Certificate of Need Process					√	√				All	Participating - Most recently regarding hospital catheter laboratory
[C][F] BCA Blue Distinction Centers					√	√				All	Participating
[C] Transplant Centers of Excellence					√	√				All	Participating
[C] Gain-Sharing and Performance Improvement							√			Not applicable	Not pursued - Applying pay for performance incentives
[C] Community-Based Fee Schedules			√				√			Excludes Plan 65 only	Implementing as appropriate - Incorporate standard community rates in fee schedules

Affordability Report

Initiative	Spectrum of Products	Appropriate Incentives for Stakeholders	Focus on Primary Care, Prevention & Wellness	Manage the Chronically Ill	Least Cost, Most Appropriate Setting	Evidence-based Quality Care	Payment Strategies for Cost Effective Utilization	Simple & Effective Administrative Processes	Consumer Need for Cost Information	Applicable Products	Status
[C] Exclusive Capitated Networks [C] BlueCHiP for Medicare Exclusive Contracts for Laboratory and DME							√			Medicare Advantage and RIte Care	Implemented
[C] WellPoint Pharmacy Benefit Manager							√	√		Excludes Plan 65 only	Implemented
[C][F] Generic Drug Sample Dispensing System		√	√				√	√		Excludes Plan 65 only	Implemented - As of November 2006, system installed in 34 offices and available to 216 physicians
[C] Pharmacy Prior Authorization for BlueCHiP for RIte Care							√			RIte Care	Implemented
[C] "New" Drug Policy							√	√		Excludes Plan 65 only	Implemented
[C] Formulary Management Strategies							√	√		Excludes Plan 65 only	Implemented
[C][F] Implementation / Expansion of Quantity Limits	√							√		Excludes Plan 65 only	Implemented for migraine medications, antiemetics, cholesterol lowering agents, allergy drugs, and osteoporosis medications.
[C] Physician Prescribing Education						√		√		All	Implemented
[F] Expand Profiling Process for Pharmacy Programs						√	√	√		Excludes Plan 65 only	Implemented - Three physicians have received a pharmacist visit over the last six months.
[F] Promote the Member Generic Voucher Program		√		√			√	√		Excludes Plan 65 only	Implemented - In October 2006 the Program was reinstituted.
[F] Enhance the Management of Specialty Pharmacy	√			√			√	√		Excludes Plan 65 only	In progress - To begin 1st Quarter 2007 with full implementation by January 2008.
[F] Promote the Appropriate Use of First Generation Antibiotics			√	√		√	√	√	√	Excludes Plan 65 only	In progress - In January 2007, the report will be targeted at 700 prescribers with first-line versus second-line use compared to their peers.

Initiative	Spectrum of Products	Appropriate Incentives for Stakeholders	Focus on Primary Care, Prevention & Wellness	Manage the Chronically Ill	Least Cost, Most Appropriate Setting	Evidence-based Quality Care	Payment Strategies for Cost Effective Utilization	Simple & Effective Administrative Processes	Consumer Need for Cost Information	Applicable Products	Status
[F] Recommend a Change to the RI Generic Prescribing Law to Reflect MA Generic Prescribing Law							√	√		Excludes Plan 65 only	On hold - Due to timing of the legislative session and need to evaluate whether to pursue since generic utilization has improved.
[F] Managed Pharmacy Benefit Option for Commercial Group Markets	√						√	√		Commercial (Small Group, Large Group)	Completed - Available to employer groups; none purchased to date.
[F] Managed Pharmacy Benefit Standard for Direct Pay Members							√	√		Direct Pay	In progress - To be included in HMC2C products effective April 2007.
[C] Standard Claims Payment Policies						√		√		Excludes Plan 65 only	Implemented
[C] Hospital Comparison Tool					√	√			√	All	Implemented
[C] Enhanced Anti-Fraud Program		√						√		All	Implemented
[C] Educating and Informing our Customers and Members									√	All	Implemented - Choices Magazine (quarterly), TV ads
[C] Improving Awareness of the Root Causes of Rising Health Insurance Premiums									√	All	Implemented - Today's Healthcare Costs newsletter, Community Meeting (9/26/06), Affordability Tips, Brochures, and Website (2007)
[F] Reimbursement for Care Plan Oversight Pilot Program (Advanced Medical Home)		√	√	√	√	√	√	√		Excludes Plan 65 only	Deferred - At the OHIC's request, to be implemented in conjunction with the statewide Chronic Care Sustainability Initiative (CSI) for RI.
[F] Support Coordination between Primary Care Physicians and Emergency Room Physicians Pilot Program		√	√	√			√			Excludes Plan 65 only	Pilot initiated

Initiative	Spectrum of Products	Appropriate Incentives for Stakeholders	Focus on Primary Care, Prevention & Wellness	Manage the Chronically Ill	Least Cost, Most Appropriate Setting	Evidence-based Quality Care	Payment Strategies for Cost Effective Utilization	Simple & Effective Administrative Processes	Consumer Need for Cost Information	Applicable Products	Status
[F] Support Coordination between Primary Care Physicians and Hospitals Physicians Pilot Program		√			√	√	√			Excludes Plan 65 only	On hold - Not started due to other priorities or inability to quantify savings and rationale for proceeding.
[F] Reimbursement to Manage Skilled Nursing and Custodial Care Members Pilot Program		√	√	√		√	√			Excludes Plan 65 only	On hold - Not started due to other priorities or inability to quantify savings and rationale for proceeding.
[F] Reimbursement for "After Hours" Access to PCPs		√	√	√	√		√	√		Excludes Plan 65 only	Implemented in Part - Increased the fee for after-hours code 99050. Deferred in Part- At the OHIC's request, a proposal was made to expand after hours access and is pending with the Primary Care Stakeholders Group.
[F] Work with the Rhode Island Medical Society (RIMS) and Regulators to Address Problem Physicians						√				All	Cancelled - Unable to reach consensus with RIMS
[F] Radiology Network: (1) Privileging (2) Preauthorization for MRI, CT, and Nuclear Cardiology						√	√			Excludes Plan 65 only	In progress - Vendor selection to be completed by the end of January 2007.
[F] Implement Medicare Multiple Radiology Procedure Policy							√	√		All	Implemented - Effective (25%) 8/1/06 and (50%) 1/8/07.
[F] Reduce the Radiology Fee Schedule							√	√		Excludes Plan 65 only	In progress - New fees effective April 1, 2007.
[F] Sponsor Radiology Educational Programs with RIMS						√	√			All	Not pursued - Contracting with Radiology Management Vendor
[F] Evaluate Reimbursement to Independent Providers of Infusion Drugs for BlueCHiP for Medicare Members				√	√		√			Excludes Plan 65 only	Completed - Decision to not pursue

Affordability Report

Initiative	Spectrum of Products	Appropriate Incentives for Stakeholders	Focus on Primary Care, Prevention & Wellness	Manage the Chronically Ill	Least Cost, Most Appropriate Setting	Evidence-based Quality Care	Payment Strategies for Cost Effective Utilization	Simple & Effective Administrative Processes	Consumer Need for Cost Information	Applicable Products	Status
[F] Conduct a Feasibility Study on a New Streamlined Reimbursement Methodology of a Single Fee-for-Service for any Place of Service						√	√			Excludes Plan 65 only	Completed - Decision to not pursue
[F] Conduct a Feasibility Study on a New Streamlined Hospital Budget Methodology						√	√			All	Completed - Decision to not pursue

Notes:

√ indicates the initiative addresses the applicable affordability principle noted.

Current [C] and Future [F] Initiatives are from the Current Affordability Initiatives plan dated January 9, 2006 and the Future Affordability Initiatives plan dated April 2006 submitted to the OHIC on April 21, 2006.

"Implemented" reflects initiatives/practices that (1) were already in effect prior to the submission of BCBSRI's Current and Future Affordability Initiatives plans in early 2006 which are on-going; or (2) initiatives/practices that have been implemented since submission of the plans. We are constantly evaluating these practices to identify appropriate modifications.